SELECTIVE CONTRACTING ARRANGEMENT

ANNUAL REPORT

FOR THE YEAR ENDING DECEMBER 31, 20_____
(Year)

_____
(Name of Insurer)

NAIC Company Code _____
Employer ID# _____

Date Incorporated or Organized: _____
Date Commenced Business: _____
Date Certified as an SCA: _____

Statutory Home Office: _____, _____
(Street and Name) (City, State, and Zip Code)

Address of Main Administrative Office: _____
(Street and Number)

_____, _____
(City, State, and Zip Code) (Area Code) (Telephone Number)

Contact Person: _____, _____
(Name) (Area Code) (Telephone Number)

_____, _____
(Fax Number) (Email Address)

For the following list, list full name of PPO/HMO, Address; Telephone number (Please indicate if an HMO network is serving as the delivery system in this SCA). Please include the name of the Principal Contact Person and his/her telephone number, fax number and email address for each PPO/HMO.

Hospital/Medical Network:
_____
_____

Prescription Drug Network:
_____
_____

Vision Care Network:
_____
_____

Dental Care Network:
_____
_____

Behavioral Health Network (Mental Health and Substance Abuse):

_____
_____

Home Health Services Network:

_____
_____

Laboratory Network:

_____
_____

Other:

_____
_____

Identify which market you are currently serving. Large group (>50 employees), Small group (2-50 employees), and / or individuals. Have you withdrawn from any market in which you were previously approved? If so please indicate the date.

_____
_____
_____

Approved Counties:

_____
_____
_____

Does your plan use a PCP as a gatekeeper? YES_____ NO_____

_____
(Signature)
(Officer of Insurer)

_____
(Printed Name)

_____
(Title)

NOTE: Pursuant to N.J.A.C. 11:37.4 (d), Any changes in operations or in previously filed documents must be filed with the Department within thirty (30) days.

SCA ANNUAL REPORT

1. Please provide Membership by County or by Zip Code (first three digits only) for the previous calendar year. (see Table I that is attached and complete a separate table for each PPO/HMO)

2. Please provide Membership by Rating Status

MEMBERSHIP BY RATING STATUS

YEAR ENDING	December 31, (N*)	December 31, (N-1*)
SINGLE EES**		
EE & SPOUSE**		
EE & CHILD**		
FAMILY**		
TOTAL		

*N=Most recent calendar year
=Indicate the number of **employees that are enrolled in each category.

3. Please complete the table for the Number of employer contracts by product:

Number of Employer Contracts by Product

Year Ending	Hospital/ Medical*	Prescription	Vision	Dental	Total
N**					
N-1					

* Which may include prescription, vision and dental on a nonstand-alone basis.
**N=most recent calendar year

4. Please complete the Plan Experience table for the SCA line of Business for the previous calendar year and prior calendar year. If any products are stand-alone, complete a separate table.

PLAN EXPERIENCE

CALENDAR YEAR	N*	N-1
PREMIUM		
INCURRED CLAIMS IN NETWORK	$	$
INCURRED CLAIMS OUT-OF-NETWORK	$	$
# OF CLAIMS IN NETWORK		
# OF CLAIMS OUT-OF-NETWORK		

*N=most recent calendar year

State of New Jersey
Department of Banking and Insurance

SCA ANNUAL REPORT

Membership by County as of December 31_____ (N*)

County**	# Single	# Employee & Spouse	# Employee & Child	# Family	Total Employees
Atlantic					
Bergen					
Burlington					
Camden					
Cape May					
Cumberland					
Essex					
Gloucester					
Hudson					
Hunterdon					
Mercer					
Middlesex					
Monmouth					
Morris					
Ocean					
Passaic					
Salem					
Somerset					
Sussex					
Union					
Warren					
Total Employees Enrolled					

Table I

***N=Most recent calendar year**
****The use of the twenty (20) three (3) digit zip codes can be used as an alternative to counties**
 # Indicate the number of Employees that are enrolled in each category